FIRST STEPS

Washington State Department of Social and Health Services
Washington State Department of Health
PO Box 47880, Olympia,WA 98504-7880 (360) 236-3580

TO: Maternity Support Services Providers

FROM: Sherilynn Casey, Manager
Maternal and Infant Health

RE: **Revised Copy of the Maternity Support Services Billing Instructions, Dated March 2002**

Enclosed is a copy of the Maternity Support Services (MSS) Billing Instructions.
A summary of the changes is shown below.

Questions about this document may be addressed to:

Diane Bailey, Coordinator	(360) 236-3580
Becky Peters, Psychosocial Consultant	(360) 236-3532
Judy Oliver, Nutrition Consultant	(360) 236-3599
Kathi LLoyd, Health Education Consultant	(360) 236-3552
Public Health Nurse Consultant	

Definitions

- Performance measure definition has been added.

MSS Required Activities

- Required activities were revised to include a Family Planning Performance Measure, Section H.

Procedure Codes, Description, and Fees

- Vendor rates were increased for Home Visiting Codes and Childbirth Education.

- New procedure code was added to compensate for follow-up consultation and data collection required by the family planning performance measure, effective July 1, 2000.

Department of Social and Health Services
Medical Assistance Administration
and
Department of Health
Maternal and Infant Health

Maternity Support Services

Billing Instructions

(WAC 388-533-0300)

March 2002

About this publication

This publication supersedes all previous Maternity Support Services Billing Instructions and the following Numbered Memorandum: 01-19 MAA.

Published in coordination with Washington State's:

Medical Assistance Administration
Department of Social and Health Services
and
Maternal and Infant Health
Department of Health

March 2002

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

Table of Contents

Table of Contents (cont).

Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)]

Program/Pre-Application Provider Questions – DOH/MIH

Policy/Program Oversite
Department of Health (DOH) – Maternal and Infant Health
(360) 236-3505

Billing Questions – DSHS/MAA

Where do I call to submit change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

Electronic billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Where do I call if I have questions regarding…

Payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov
[Provider Publications/Fee Schedules]

or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

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Definitions

This section contains definitions, abbreviations, and acronyms used in these billing instructions that relate to the Medical Assistance program. The definitions are presented as a guide for the provider's use. They are not intended to be inclusive, nor are they intended to inhibit professional judgement. The criteria apply to all providers and contractors.

ADATSA/DASA Assessment Centers - ADATSA refers to the Alcohol and Drug Addiction Treatment and Support Act. DASA is the Division of Alcohol and Substance Abuse. Agencies contracted by DASA to provide chemical dependency assessment for ADATSA clients and pregnant women. Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.

Childbirth Education - A series of educational sessions taught by approved instructors that prepare pregnant woman and/or prospective parents for an upcoming childbirth. Clients and optional support persons attend either group or individual sessions, depending upon their specific needs.

Childcare:

DASA - Childcare is funded through DASA for the children of pregnant and postpregnancy women so those women can attend outpatient alcohol or drug treatment services. DASA childcare must be provided by a licensed childcare agency or through an approved treatment facility or program.

First Steps - Childcare funded through the First Steps Program for the care of children of pregnant or postpregnancy women who are attending appointments for Medicaid-covered services.

Child Protective Services (CPS) - The program within the Division of Child and Family Services authorized by statute (RCW 26.44) to receive and investigate referrals of child abuse, neglect, and exploitation.

Children with Special Health Care Needs (CSHCN) - Title V (federally funded) program for children with special health care needs.

Client - An applicant for or recipient of DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community and Family Health (CFH) - The division within the state Department of Health whose mission is to improve the health and well-being of Washington residents, with a special focus on infants, children, youth, pregnant woman, and prospective parents.

Community Services Office (CSO) - An office of the department [The Department of Social and Health Services (DSHS)] that administers social and health services at the community level. [WAC 388-500-0005]

Contractor - The primary Maternity Support Services (MSS) provider of service to MSS clients. The contractor signs MAA's Core Provider Agreement and follows all requirements.

Core Provider Agreement - A basic contract that the [DSHS] Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation with Medical Assistance.

DASA - See ADATSA.

Department of Health (DOH) – The agency whose mission is to protect and improve the health of people in Washington state.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – (Formerly known as the "healthy kids" program) Means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.
[Refer to WAC 388-500-0005]

EPSDT Provider - (1) A physician, advanced registered nurse practitioner (ARNP), or public health nurse certified as a EPSDT provider; ***or*** (2) a dentist, dental hygienist, audiologist, optometrist or ophthalmologist who is an enrolled Medical Assistance provider and performs all or one component of the ESPDT screening.

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Federal Aid - Matching funds from the federal government received by the state for medical assistance programs.

First Steps - The 1989 Maternity Care Access Act, known as First Steps. This program provides maternity care for pregnant and postpregnant women and health care for infants. The program is administered jointly by DSHS and DOH. First Steps maternity care consists of obstetrical care, case management, and support services such as community health nursing, nutrition, psychosocial visits, and childbirth education classes. Ancillary services include expedited eligibility determination, case finding, outreach, childcare, and transportation. Specialized substance abuse treatment services, offered through the Omnibus Drug Act, encompass residential and outpatient treatment and transitional housing.

First Steps Childcare – See "Childcare."

Healthy Options program or HO program – The Medical Assistance Administration's (MAA) prepaid managed care health program for Medicaid-eligible clients and CHIP clients.
[WAC 388-538-050]

Interagency Agreement - A written letter of agreement between two agencies for the exchange of referrals or service provision (e.g., a written agreement in letter format that agrees to an exchange of referrals or services for MSS clients).

Intra-Agency Agreement - A written letter of agreement within different departments of a large agency (e.g., a written agreement in letter format that clarifies the exchange of referrals or services between the MSS contractor and the mental health office within the same agency).

Local Match - Nonfederal funds provided by local entities to match the federal Title XIX funds provided for a given program.

Managed care – A comprehensive system of medical and health care delivery including preventive, primary specialty, and ancillary health services. These services are provided through a managed care organization (MCO) or primary care case management (PCCM) provider. [WAC 388-538-050]

Maternal Infant Health (MIH) – A section within the state Department of Health. MIH is the program section responsible for administering the Maternity Support Services program.

Maternity Case Management (MCM) - Services which will assist individuals eligible under the Medicaid state plan to gain access to needed medical, social, educational, and other services (Social Security Act 1915[g]). Maternity case management includes the following and are done in a prescribed and accountable manner:

- Advocacy and linkage with community resources;
- Comprehensive and on-going identification of needs (medical, social and educational); and/or
- Development and implementation of a detailed plan of services and related activities for the client.

Maternity Support Services (MSS) - Preventive health services for pregnant/postpregnancy women including: assessment, education, intervention and counseling provided by an interdisciplinary team of community health nurses, nutritionists, and psychosocial workers. Childbirth education, authorization of childcare, and community health worker visits may also be provided.

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to:

- Categorically needy as defined in WAC 388-503-0310 and 388-503-1105; or
- Medically needy as defined in WAC 388-503-0320. [WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration authorized by the Secretary to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly "course of treatment" available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Patient Identification Code (PIC) - An alphanumeric code assigned to each MAA client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tiebreaker).

Performance Measure - An indicator used to measure the results of a focused intervention or initiative.

Postpregnancy Period – The two months following a live birth, miscarriage, fetal death, or pregnancy termination.

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Disease Management;
- Family Planning Services;
- First Steps;
- Field Services;
- Managed Care Contracts and PCCM; and
- Provider Relations.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance and Status Report *(formerly referred to as a Remittance Advice or "RA")* **–** A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration [DSHS] that provides detailed information concerning submitted claims and other financial transactions.

Referral Agreement - A written letter of agreement with another agency or service provider to which referrals of MSS clients will be honored and encouraged (i.e., an MSS contractor develops a Referral Agreement in letter format to refer MSS clients they are serving to a program that meets MSS requirements).

Refugee – According to WAC 388-466-0005, a person who can prove, by providing documentation issued by the Immigration and Naturalization Service (INS), that he or she was:

(a) Admitted as a refugee under section 207 of the Immigration and Nationalities Act (INA);
(b) Paroled into the U.S. as a refugee or asylee under section 212 (d)(5) of the INA;
(c) Granted conditional entry under section 203 (a)(7) of the INA;
(d) Granted asylum under section 208 of the INA;
(e) Admitted as an Amerasian Immigrant from Vietnam through the orderly departure program, under section 584 of the Foreign Operations Appropriations Act, incorporated in the FY88 Continuing Resolution P.L. 100-212;
(f) A Cuban-Haitian entrant who was admitted as a public interest parolee under section 212 (d)(5) of the INA.

Revised Code of Washington (RCW) - Washington State laws [http://wsl.leg.wa.gov/wsladm/rcw.htm].

Staff - Personnel employed by providers/contractors who provide services to MSS clients.

Subcontractor - An individual or agency who has contracted with a primary MSS provider to provide services to MSS clients. This individual or agency must be informed of, and comply with, all regulations contained in the Core Provider Agreement as they pertain to service delivery to the MSS client. (These include the MSS Billing Instructions.)

Supervision – A process that involves both monitoring and teaching. Supervision should begin prior to intervention and documented as to date, subject matter, follow-up plan, and parties involved. (See "staffing requirements, page C.3.)

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.
[WAC 388-500-0005]

Usual and Customary Fee - This is the rate that may be billed to the department for a certain service or equipment. This rate *may not exceed* 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate for the same services normally offered to other contractors.

Washington Administrative Code (WAC) - Codified rules of the state of Washington. [http://www.mrsc.org/wac.htm]

WIC (Women, Infant, and Children) - A special supplemental nutrition program for women, infants, and children.

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About the Program

What is the purpose of the Maternity Support Services program?

The goal of the Maternity Support Services (MSS) program is to provide enhanced services to include health education, intervention, and support to eligible women during and after their pregnancy. The program is designed to provide MSS interventions as early in a pregnancy as possible in an effort to promote a healthy pregnancy and positive birth and parenting outcomes. The Department of Social and Health Services (DSHS) and the Department of Health (DOH) work in cooperation to make this possible.

What is MSS?

MSS is individual, face-to-face visits approximately 30 minutes or longer in duration by one or more of the following members of an interdisciplinary team:

- Professional members (community health nursing, nutrition, and psychosocial services)
- Paraprofessional members (community health workers)

MSS, in addition to the visits described above, also includes childbirth education classes. (See Section F)

MSS includes assessment, development, implementation, and evaluation of plans of care for pregnant women through two months postpregnancy. **MSS is in addition to routine obstetrical care.**

Community health workers assist in implementing the plan of care by providing health education and assisting clients in following through with their plans of care (see Section E).

Referrals

Referrals may come to MSS agencies from:

- Maternity case managers;
- Community Services Office (CSO) staff;
- Clinics;
- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Midwives;
- Special supplemental nutrition program for women, infant, and children (WIC);
- Family planning agencies;
- Local health jurisdictions (public health departments);
- Home health agencies; and
- Other referral sources (e.g., Healthy Options plans, Basic Health Plan, and self-referrals).

How long is MSS available?

MSS may be initiated during the prenatal, delivery, or postpregnancy periods. An eligible client may choose to receive MSS from any MAA-approved MSS provider. Eligible clients may receive MSS during pregnancy and through the end of the month during which the 60th day after the end of the pregnancy occurs.

How many MSS visits are covered?

MAA covers up to ten MSS visits per pregnancy/postpregnancy period, per client.
If a client is determined to be at high-risk* for a poor birth outcome, **MAA may cover up to 20 MSS visits** per pregnancy/postpregnancy period. Maternity case management (MCM) visits do not count towards the maximum of 20 MSS visits.

> ****High-risk clients*** are those meeting the eligibility criteria for maternity case management (see page E.2). Document the client's MCM eligibility criteria in the client's chart that allowed for the 10 additional visits.

Freedom of Choice/Consent

MSS clients have the right to choose their MSS provider, and (if not enrolled in a managed care plan) any other MAA provider, as allowed under Section 1902(a)(23) of the Social Security Act.

1. **Option to Receive Services**
   Any pregnant Medicaid client has the *option* to receive MSS but *cannot be forced* to receive MSS services for which she might be eligible (Social Security Act - Section 1915(g)(1)).

2. **Free Choice of Maternity Support Services Providers**
   MSS clients (fee-for-service and managed care) have free choice of MSS from any approved provider statewide. **You may not limit the client to MSS providers in a given county or clinic, even if the client receives all other MAA-covered services through that county or clinic**.

3. **Free Choice of Other Providers**
   Clients must have free choice of providers of other medical care. Client's enrolled in a managed care plan must use a provider in the managed care plans network for medical care.

Consent/Refusal
Document the client's consent or refusal to receive MSS in the client's record.

Confidentiality and Release of Information

Providers must have policies and procedures that safeguard the confidentiality of the client's records. These policies and procedures must:

- Allow for timely sharing of information with appropriate professionals and agencies on the client's behalf; AND
- Ensure that confidentiality of disseminated information is safeguarded.

Providers must have policies and procedures for a release of information:

- Prior to any disclosure of client-specific information or records including, but not limited to, treatment and testing for sexually-transmitted diseases (including HIV/AIDS), substance abuse and/or mental health treatment.
- To transfer pertinent MSS records to another MSS provider when a client changes providers. (The transferring agency is required to provide the new MSS provider with client-specific information, such as the MSS intake criteria, assessment form, and current plan of care.)

A release of information is not necessary when:

- DSHS CSO staff makes a referral for MSS to an agency with which DSHS has a contract for this specific service.

- The contracted agency provides DSHS with information on any services that are provided.

Client Eligibility

Please remember: Any pregnant MAA client is eligible for MSS and certain pregnant clients are also eligible for Maternity Case Management. Refer to MAA's Maternity Case Management Billing Instructions for further information on Maternity Case Management.

Who is eligible for MSS?

To be eligible for MSS, a client must:

- Be pregnant or within 60 days postpregnancy; and
- Present a DSHS Medical Identification (ID) card with one of the following identifiers:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP Children's Health	Categorically Needy Program - Children's Health
CNP – CHIP	Categorically Needy Program - Children's Health Insurance Program
CNP-Emergency Medical Only	Categorically Needy Program- Emergency Medical Only

☞ **Note:** If the client is pregnant but her card does not list one of the above medical program identifiers, please refer her to the local Community Services Office (CSO) to be evaluated for a possible change in her medical assistance program that would enable her to receive full scope maternity care.

Are clients enrolled in a Healthy Options managed care plan eligible for MSS?

Yes! Clients who are enrolled in a Healthy Options managed care plan are eligible for MSS outside their plan. MAA reimburses for MSS through its fee-for-service system. Coverage and billing guidelines found in these billing instructions apply to managed care clients.
Bill MAA directly.

Clients who are enrolled in managed care will have an "HMO" identifier in the HMO column on their DSHS Medical ID cards.

Provider Requirements

How does an agency qualify to become an MSS provider?

To qualify as an MSS provider, an agency must:

- Be approved by the Department of Health-Maternal Infant Health (MIH)
  For information call (360) 236-3505.

- Meet the agency and MSS staffing requirements listed below.

Once approved, MAA assigns a separate MAA provider billing number for MSS.

Agency Requirements

A qualified MSS agency must meet all of the requirements listed below:

1. **An interdisciplinary team is required**. The team must include members from the following professional disciplines who meet the listed requirements (see page C.3): nursing, psychosocial, and nutrition. At least one of these disciplines must be provided directly by the agency. Agreements to provide the other disciplines may be subcontracted (refer to page C.2).

2. The agency must:

   - Have experience in the delivery of services to the target population;
   - Demonstrate an understanding of the concept and delivery of MSS;
   - Be able to demonstrate linkages to relevant service and health care organizations in the area to be served;
   - Conduct activities that inform the target population and health care providers in the geographic area to be served of its MSS. Such activities might include: agency brochure distribution, newspaper and newsletter articles, announcements to local providers, posters, and attendance at First Steps provider meetings in the adjacent service area;

- Have written agreements with Maternity Case Management agencies and ADATSA/DASA assessment centers to define referral relationships and communication mechanisms;
- Have or develop a close working relationship with other community agencies and programs including: CSOs, WIC, family planning, mental health centers, health plans, EPSDT clinics and schools;
- Attempt to avoid duplication of services to individuals served by multiple agencies.
- Participate in state program monitoring activities; and
- Have the capacity for home visiting either through their agency or through an agreement with a subcontractor or another approved MSS agency. At least one home visit in the prenatal period and one home visit in the postpregnancy period is recommended.

3. Providers of MSS will work collaboratively to meet the client's individual needs in a manner that shows sensitivity to the client's culture, ethnicity, religion, values, and goals.

Subcontracting

The MSS provider agency is responsible for making sure the subcontractor complies with the requirements in these billing instructions as though the provider were furnishing the services directly. In cases where services are provided through a subcontractor, the subcontractor's letter of agreement must be on file for review by the MIH program staff. Names of contracted staff must be included on the MSS State roster when submitted to MIH.

To be qualified as an MSS subcontractor, the contractor must meet all of the staffing and required activities of these billing instructions. At a minimum, the contract must include:

- A description of the qualifications of personnel;
- Documentation requirements;
- Subcontractor participation in the development and revision of the client's plan of care; and
- The manner in which services will be coordinated and evaluated by the provider agency.

☞ **Note:** If an unqualified employee provides MSS services, MAA considers this an erroneous billing and recoups any resulting overpayment during an agency Medicaid audit.

Staffing Requirements

Criminal background checks and reference checking are strongly recommended as part of the screening process for all personnel. Criminal background checks may be obtained through the Washington State Patrol.

a. **Community Health Nursing** - A registered nurse with a bachelor of science degree in nursing, including course work in public health; or a registered nurse with two years of documented experience in parent-child nursing.

b. **Psychosocial**

Level I: A registered counselor in the state of Washington with a master's degree in Psychology, Social Work, Marriage and Family Therapy or Educational Psychology from an accredited school with an internship or practicum experience in direct counseling services. In addition, **one year** (40-hour week; not internships or practicum) **supervised experience** with direct counseling services to clients.
-OR-
Licensure within the state of Washington as a Social Worker, Mental Health Counselor, Marriage and Family Therapist, or Psychologist automatically meets the Level I psychosocial requirements.

Level II: A registered counselor in the state of Washington with a master's degree in Psychology, Social Work, Marriage and Family Therapy, or Educational Psychology from an accredited school with an internship or practicum in direct counseling and **less than one year supervised experience** in direct counseling services to clients.
-OR-
A registered counselor in the state of Washington with a bachelor's degree in Psychology, Social Work, or Educational Psychology from an accredited school plus **two years of supervised experience** in direct counseling services to clients.

An individual who meets the criteria of a Level I staff must provide clinical supervision to all Level II staff; the supervision must be documented. To discuss the development of the supervision plan, call the DOH Psychosocial Consultant.

c. **Nutrition** - Currently registered as a dietitian with the American Dietetic Association Commission on Registration. At least one year of experience (40 hour week; not internships or practicums) in community public health or maternal/child health is strongly recommended.

d. **Community Health Worker (CHW)** - (Optional MSS staff position):

The required qualifications for this position are:

- A high school diploma or the equivalent; AND
- One year of health and/or social services experience.

All CHW activities must be carried out under the supervision of at least one of the following professional members of the MSS team:

- A community health nurse;
- A psychosocial worker; or
- A nutritionist.

See page E.6 for an explanation of the supervision requirements and role.

The recommended qualifications for this position are:

- Be part of the local community, meaning the CHW reflects the linguistic, ethnic, cultural and socio-economic characteristics of the community;
- Have experience with the target population in the community;
- Have status as a positive role model in the community;
- Demonstrate the ability to work independently and as part of the MSS team;
- Have a clear understanding of the federal, state, and community resources available;
- Possess the ability to conduct reliable education and outreach in the community;
- Clearly understand and agree to the parameters of this role. Know when, why, and how to refer to the MSS professional team members appropriately;
- Agree to meet the needs of the clients by providing unbiased and factual education and/or referral(s), even if the client's needs might be in conflict with the personal viewpoint or belief system of the CHW.

The scope of practice of a CHW must **not** include performing the professional MSS initial assessment or **independently** developing and/or carrying out any part of the client's plan of care (see page E.6 for further details regarding the CHW's scope of practice and supervision requirements).

☞ **Note:** If an unqualified employee provides MSS services, MAA considers this an erroneous billing and recoups any resulting overpayment during an agency Medicaid audit.

e. Labor Support (commonly referred to as a "Doula")

Labor support visits are reimbursed through Medicaid as a part of MSS under all of the following conditions:

1. The person providing labor support meets the qualifications for Community Health Worker.
2. The labor support visits consist of educational and supportive interventions. An outline of topics that may be included in client visits must be submitted to the Department of Health, Community and Family Health, MSS Health Education Consultant, prior to providing labor support visit.
3. The labor support person's activities must be carried out after consultation with a professional member of the MSS team.
4. Labor support visits are included in the ten-visit limit for each client (20-visit limit for high-risk clients eligible for Maternity Case Management).
5. A labor support person not employed by a local MSS agency must have a written agreement with that agency. A copy of this written agreement must also be on file with the Department of Health. The written agreement must specify which agency will bill for these services. Services need to be coordinated with primary MSS agency and identified within the plan of care.

Note: MSS reimbursement is not available for staff who:

1. Provide only interpreter services;
2. Perform agency clerical work that is above and beyond MSS documentation requirements; or
3. Provide transportation.

Exceptions to Staffing

An agency is required to initiate and be granted an exception request for any MSS staff not meeting the qualification described previously. If there is not an approved exception then no MSS billing is allowed for that staff person. If billing has already occurred for services rendered by an unqualified person, the agency may be required to repay MAA.

The written exception request must include:

- Agency recruitment efforts;
- Candidate's relevant skills, experience, and cultural sensitivity in working with clients and families;
- Availability of clinical supervision by a MSS team member who exceeds the minimum qualifications for the applicant's discipline. Describe the plan for clinical supervision;
- Provisions for the applicant to receive additional training and course work in necessary areas;
- For midlevel practitioners requesting exception, a description of how MSS will be provided to the client by that practitioner separate from usual and customary medical care; and
- The extent to which MSS access will be jeopardized if staffing exception is not approved.

Send the written exception request to:

DOH – Maternal & Infant Health
PO Box 47880
Olympia, WA 98504-7880

Upon receipt of the written exception request, the MSS State Consultant will review the request and contact the requesting agency. The final determination as to whether the exception is granted will be in writing to the provider and a copy placed in the MSS provider file.

Quality Assurance

Quality Assurance Components Include:

- Orienting both administrative and direct service staff to the program;
- Developing and implementing a client satisfaction process;
- Evaluating the MSS interdisciplinary team. This includes, at a minimum, a review of team function, identifying numbers and types of clients receiving services, assessing utilization and number of MSS visits by discipline documentation, and linkages with other services; and
- Implementing a quality assurance program which includes:
  - ✓ A self-monitoring tool. A sample is available from the Department of Health, to use as one component for examining quality.
  - ✓ Encouraging new staff to attend the "ABCs of First Steps" training (a two-day session offered several times throughout the year).
  - ✓ Responding to all referrals within two weeks of receiving the referral or documenting your efforts to respond timely.
  - ✓ Scheduling and providing services in office, clinic, and homesetting to accommodate the client's situation/needs. Providing bilingual or interpretation services, if needed.

A good foundation for quality assurance is having an identified MSS Coordinator.

MSS Coordinator

The MSS Coordinator is a professional member of the team who will assure that the MSS and MCM programs are implemented according to the provisions described in the MAA Core Provider Agreement, the MSS Billing Instructions, and the MCM Billing Instructions.

The coordinator establishes a mechanism to oversee the management and fiscal affairs of the MSS and/or MCM programs, which may include the following:

- Organizing and directing the ongoing function of client services;
- Maintaining accurate documentation of client, personnel and billing records;
- Assuring accuracy of public information materials;
- Recruiting and retaining qualified staff, and implementing an orientation and training plan and a method for regularly scheduled evaluations;
- Implementing a quality improvement plan to include: identifying and correcting problems; evaluating client satisfaction; and processing complaints;
- Acting as a liaison between the MSS agency and state agencies involved in the MSS program;
- Informing the state of staffing changes; and
- Participating in community collaboration of MSS delivery and, if applicable, Maternity Case Management delivery.

Direct Client Service Requirements

Orientation

An MSS agency must orient clients to the First Steps Program. At a minimum, orientation must include:

- A description of First Steps services;
- An explanation that First Steps services are voluntary, and that the client may receive services from a provider of her choosing; and
- An explanation of confidentiality and the information release policies of the agency.

Initial Assessment (Screening)

Initial assessment is the first step in defining the client's strengths and needs. It is the cornerstone of the client's plan of care and identifies the need for more thorough discipline-specific assessment. Continued assessment as care progresses (as services are provided) is essential to meeting the client's needs. The assessment includes data collection, as well as professional observations.

Information required in the initial assessment may have been collected by other sources such as the CSO social worker, prenatal care provider, and/or WIC staff. This information may be shared with your agency with the client's written consent.

One or more members of the MSS professional staff must do the initial assessment.
Initial assessment includes, but is not limited to, screening for MCM eligibility (see page E.2) and the client's knowledge and understanding of the following:

- Pregnancy, childbirth, and parenting (including client's cultural or religious beliefs/practices).
- Major health risks including HIV, Hepatitis B, and other warning signs in pregnancy.
- Utilization of health care resources, including dental and vision services.
- Family planning services and birth control methods.
- Benefits of breast-feeding.
- Dietary patterns and intake, and resources for obtaining and preparing food.
- Risks of tobacco use and exposure, and alcohol and drug use during pregnancy, including over-the-counter and prescription drugs.
- Family structure, support system, roles and relationships, coping ability, stress level, and mental health status.
- Home and work environment, including housing, safety and security, occupation, transportation and access issues, and financial resources.
- Assessing the need for First Steps Childcare if not receiving MCM (see page G.1).
- Infant eligibility and linkages to pediatric primary care, parent-infant bonding, infant care concerns, parenting resources, infant safety, immunizations, and infant health status.

Screening for MCM Eligibility

Some pregnant women have a higher risk than others for poor birth outcomes due to age, medical or mental condition, lack of access to appropriate care, and other reasons. Therefore, the targeted population for Medicaid funded MCM is high-risk pregnant/parenting women who have been determined eligible for Medicaid **and meet at least one of the following two criteria:**

- Be 17 years of age or younger; or
- Using alcohol/drugs and/or living in an environment in which alcohol/drugs are present.

-OR-

Meets <u>at least three</u> of the following criteria:

1. Is homeless, staying with friends and relatives on a short-term basis, or is staying in shelters;
2. Is a victim of current or recent violence (e.g., physical or sexual abuse, Child Protective Services [CPS] involvement);
3. Is lacking a support system and/or involvement of partner;
4. Has medical factors related to her pregnancy outcome, such as HIV/AIDS, diabetes, hypertension, chronic illness, multiple gestation (twins, triplets), previous preterm birth, cigarette smoking (more than six per day);
5. Has two or more children, 4 years of age and under, in the home;
6. Has an eighth grade education or lower;
7. Has a physical disability;
8. Has a mental impairment/depression (such as learning disability, history of special education or cognitive delay);
9. Received her first prenatal care after 28 weeks gestation;
10. Qualifies for refugee status (This does not include undocumented aliens; see Definition section);
11. Is 18 or 19 years of age; or
12. Has a limited English proficiency.

Once a pregnant woman begins receiving MCM, the mother and infant may continue to receive services until the infant is one year of age, as long as either the mother or the infant remains eligible for Medicaid and there is an active service plan. MCM services must begin during a woman's pregnancy or prior to the date of discharge from the hospital or birthing center of the eligible birth mother or eligible newborn child.

Discipline Specific Assessment

Nursing, psychosocial, and nutrition practitioners are encouraged to use discipline-specific tools to assist in gathering additional data beyond the initial assessment. The additional collaborative discipline specific assessments should supplement, but not duplicate, information collected in the initial assessment. The additional assessments should contribute to identifying priorities and outcomes, and serve to determine future on-going interventions and assessments. Determining a priority comes from comprehensive, systematic assessment and listening carefully to client concerns.

Plan of Care

The plan of care utilizes information obtained in the initial assessment and discipline specific assessments, if applicable. The plan of care is the working document for the interdisciplinary team describing each specific intervention and the facilitator for each invention. Document outcomes in the client's plan of care as the intervention is completed or services are terminated. Intervention provided by the MSS/MCM team will change as services are provided and the client's pregnancy progresses. The interventions in the plan of care must reflect the changing needs of the individual and her family.

Interdisciplinary plan of care for MCM-eligible clients must be developed and/or reviewed by all members of the MSS team and case manager. It is also recommended that all members of the MSS team review the plan of care for MSS-only clients.

Case Conferencing

Purpose:

1. Coordinate client services;
2. Clarify client issues;
3. Review interventions to date;
4. Revise plan of care as necessary;
5. Increase team communication;
6. Integrate discipline-specific interventions into plan of care; and
7. Reduce duplication of services and maximize effective use of discipline expertise.

Process:

1. An initial case conference is required for each MSS client who has been referred, or is receiving, MCM services. It is recommended that case conferencing is also done for MSS-only clients.

2. The initial case conference should occur within one month of the initial assessment. Following the initial assessment, on-going case conferences are needed to ensure that the client's needs are met and to reduce duplication of services.

3. **Participants in team conferences include, but are not limited to:**

   - MSS team members (nursing, psychosocial, nutrition, community health worker);
   - The MCM provider;
   - The OB provider when possible; and
   - The chemical dependency counselor when possible (when client is eligible for and receiving such services).

4. Keep documentation of case conferences in the client's chart. Documentation can be in the form of a narrative note, encounter log sheet, separate case conference form, or it can be noted directly on the interdisciplinary plan of care. Each case conference must be documented, dated, and signed by those participating.

Implementation of Interdisciplinary Plan of Care

Two important functions of the MSS agency are to assure that:

- Pregnant/postpregnancy clients and their family members are receiving appropriate services; and
- The MSS team is effective and efficient in meeting the client's/family members' needs as identified in the plan of care.

If a client is enrolled in MCM, linkages and referrals are the responsibilities of the case manager. It is the MSS provider's responsibility to discuss the need for referrals and linkages with the client's case manager.

MSS providers should follow-up on referrals made to MCM providers until confirmation is received that the client is receiving MCM services. It is imperative that MSS staff and the MCM provider communicate on a monthly basis concerning progress or changes in the client's plan of care.

Implementation of the client's plan of care includes:

1. Referral to obstetrical care and on-going communication with the prenatal provider, directly for MSS clients, and either directly or through the case manager for MSS/MCM clients.

2. All exceptionally high-risk clients (those who meet the eligibility for MCM) must have the involvement of the three main disciplines of nutrition, psychosocial and community health nursing. Involvement can be either a **face-to-face** encounter or a review/approval process of the client's plan of care. Documentation of the client encounters or review/approval by all three disciplines must be clearly noted in the client's record.

3. All MSS visits must be a minimum of 30 minutes in length.

4. Intervention, education, and counseling as needed to carry out the interdisciplinary plan of care; authorization of childcare when appropriate; and documentation of all referrals.

5. A *minimum* of one prenatal and one postpregnancy nursing visit is recommended to assess the health status of the client and newborn.

6. For clients enrolled in WIC, MSS must build upon the federally required services provided through WIC in order to prevent duplication of services. Coordination and communication with the client's WIC provider is essential.

7. Referral to ADATSA/DASA assessment center when indicated by the MSS assessment(s).

8. **All Community Health Worker (CHW) activities must be carried out under the documented and proactive supervision by at least one of the MSS professional team members.**

   Before any one on one activities between a CHW and a client can take place, the designated supervisor of the CHW must document (including signatures of the supervisor and CHW) what topics the CHW will cover and what the role and responsibilities of the CHW will be in carrying out the client's plan of care.

   To discuss the development of a CHW supervision plan, call the DOH Health Educator Consultant.

   The CHW's primary role is to provide supplemental and basic health and safety education to clients. With appropriate supervision, experience, and training, a CHW's scope of practice may include, but is not limited to:

   - Enrolling and orienting new First Steps clients;
   - Explaining scope of services available through MSS and MCM programs to new clients;
   - Assisting clients to plan and carry out the MSS plan of care;
   - Appropriate utilization of health care services in the community;
   - Nutrition education
   - Avoidance of harmful substances during pregnancy education;
   - Family planning services;
   - Lactation education; and
   - Other health and safety related behaviors.

   CHWs may provide services either at the agency site or at a client's home. CHWs are to be included in the development of the plan of care and case conferences.

   All CHW interactions with clients MUST be at least 30 minutes in length in order to bill MAA for CHW services.

Current Performance Measure

MSS providers include in their interventions a focus on family planning education so each woman can decide if she wishes to use birth control and which method would work the best for her.

Effective July 1, 2000, MSS agencies must include Question 4 from the Family Planning Interview Guide in client's record and, upon request, report the information to the state program for data collection. The complete Family Planning Interview Guide is available on-line at: http://maa.dshs.wa.gov/firststeps.

WITHIN THE 60 DAY POST PREGNANCY PERIOD

MSS/MCM Unintended Pregnancy Performance Measure:

		Yes	No
4a.	Pregnancy planning has been discussed with the client.	•	•
4b.	Client has initiated contraceptive method. (**If no, go to question #8.**)	•	•

If yes, check all contraceptive methods that apply:

- Implant
- Injectable
- IUD
- Female Sterilization
- Oral Contraceptives
- Emergency Contraception
- Other – List: _____
- Condom (male)
- Condom (female)
- Diaphragm
- Cervical Cap
- Spermicides
- Vaginal Ring
- Male Sterilization
- Breastfeeding
- Withdrawal
- Abstinence
- Natural Family Planning
- The Patch

What records must be kept in the client's file?

General Requirements for Providers:

[Refer to WAC 388-502-0020]

Providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth [record PIC, see definition on page 4];
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service; and
  - ✓ Plan of treatment and/or care, and outcome.

- Assure that the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains authenticates charts.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

Specific to MSS Agencies:

Minimum client record documentation for MSS agencies consists of the following:

- Written documentation in the client's file that all areas listed under *Freedom of Choice/Consent* and *Confidentiality and Release of Information* (see page A.3) have been addressed. **Release of client information must be signed by the client and renewed every 90 days.**
- Completed initial assessment and discipline-specific assessments.
- Childcare Screening (see page G.1).
- Plan of care (see page E.3).
- Written documentation of MCM eligibility screen, follow-up, and on-going communication with the maternity case manager.
- Written documentation of any referrals.
- Case conferences (see page E.4). Examples: narrative notes, signatures on the plan of care, or encounter log sheet.
- Evidence of on-going communication with the prenatal medical care provider, when possible.
- Family planning performance measure information (see page E.7 under **Current Performance Measure**).

Note:

- When narrative charting is used, entries should be brief, legible, and concise.
- Billings must be clearly matched with interventions.
- Documentation must reflect MSS comprehensive assessment and intervention services that are **beyond the usual and customary** medical care.
- Documentation for MSS and Maternity Case Management must be separately entered.
- All interdisciplinary team members should provide documentation of client interactions in the same chart.

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MSS Childbirth Education

Purpose

Childbirth education is intended to help the client and her support person(s) to understand the changes the client is experiencing, what to anticipate prior to and during labor and delivery, and to develop positive parenting skills. Childbirth education should be provided in a culturally appropriate manner.

What is covered?

- Childbirth education is reimbursed once per client, per pregnancy.

- Childbirth education is the only MSS service that is reimbursed either individually or as group sessions. If the client is enrolled in a group class, the client must attend at least one group class in order for an approved provider to bill for this service. However, if the client chooses to receive individual childbirth education, it can be billed if the following criteria are met:

    1. The education is provided by the MSS nurse, or state-approved MSS childbirth educator who meets the requirements listed on page F.2;
    2. If provided by the MSS nurse, this education is "above and beyond" the MSS nursing visit;
    3. The complete required childbirth education curriculum is covered (including the hospital/birthing center tour) and documented in the client's plan of care and chart; and
    4. The support person(s) are included in at least one of the individual sessions and also attend the hospital/birthing center tour.

Who can provide childbirth education?

Childbirth education may be provided by:

- A qualified employee of the MSS agency; or
- An approved MSS childbirth education provider.

An MSS Childbirth Educator must have an MSS provider number and one or more of the following criteria must be met:

1. An International Childbirth Education Association Certification;
2. Two years nursing experience in a maternal health program or maternity unit of a hospital.
3. Completion of a state approved childbirth education training program. For further clarification, please contact the MSS Health Education Consultant (see address below).

Separate Provider Number for MSS Childbirth Education

An agency or an individual may request to receive a separate provider number for childbirth education by sending all of the following materials to the MSS Health Education Consultant:

1. A letter from, or co-signed by, an approved MSS provider asking that a separate provider number be assigned to the requesting agency or person to allow billing for childbirth education;
2. An outline of the childbirth education curriculum that will be followed (see Content Requirements page F.4 for an outline of topics that must be included);
3. Qualifications that meet the state requirements of the person(s) who will be providing childbirth education; and
4. A signed Core Provider Agreement, which may be obtained by writing to the address in the box below.

Use this address to request a Core Provider Agreement be sent to you and also to send Childbirth Education applications to:

DOH – Maternal Infant Health
Maternity Support Services,
Health Education Consultant
PO Box 47880
Olympia, WA 98504-7880

Who is eligible to receive childbirth education services?

All pregnant clients are eligible for childbirth education services and **should be encouraged to participate.**

Clients seeking ONLY childbirth education may receive this service from a state-approved provider without an MSS referral or assessment. The childbirth education provider is encouraged to make clients aware of MSS and MCM services available to them in the community.

What must be included in the childbirth education services?

The childbirth education curriculum requirements are outlined on the next page.

Any changes to the curriculum and course description must be approved by the MSS Health Education Consultant in order to continue billing for this service.

See next page for Requirements for Childbirth Education Curriculum.

Requirements for Childbirth Education Curriculum

Pregnancy

- Physical and emotional changes in pregnancy
- Nutritional needs of mother and fetus
- How to prepare to breastfeed

Labor and Delivery

- Signs and symptoms of labor
- Coping skills
- Breathing and relaxation exercises
- Support techniques for patient
- Use of doulas, elders, or other support persons
- Cultural birth practices
- Types of deliveries
- Episiotomy
- Avoidance of complications
- Analgesia and anesthesia options
- Hospital routines and tour of hospital/birthing center

Postpregnancy

- Postpregnancy physical and emotional changes
- Feelings of partner
- Potential stresses within family
- Sexual responses
- Family planning methods and information on community resources that provide family planning services
- Breast-feeding issues/support

Infant Care

- Safe sleep position (on the back)
- Infant car seat
- Immunizations
- Alternative cultural practices such as care of navel and circumcision
- Importance of well-child care
- Eliminating/Decreasing environmental tobacco smoke exposure

Whenever possible, classes should be taught in the language of the participant. The client's culture, ethnicity, religion, and values should always be incorporated into the curriculum.

Educational materials should be chosen based on reading level, cultural appropriateness, and accuracy. A variety of materials, including videos, charts, and teaching aids may be used.

First Steps Childcare

Screening for childcare needs is required when the client is not receiving MCM services. (Case managed clients are screened by the case manager.)

If childcare is identified as a need and childcare is not available to the client, the MSS provider may authorize an appropriate number of time-limited First Steps Childcare billing forms. The purpose of offering childcare to MAA-eligible pregnant/parenting women is to improve birth outcome and to remove one of the barriers in accessing medical care.

The client may be screened and receive authorization for First Steps childcare throughout her pregnancy and up to 60 days postpregnancy for the following reasons:

1. Client is receiving MAA-covered services;
2. Client is on provider-ordered bedrest;
3. Client is in labor and delivery; or
4. Client needs to visit a hospitalized newborn.

MAA approval is required for First Steps Childcare for bedrest and when visiting a hospitalized newborn. For further details and to obtain the billing form, see the First Steps Childcare Billing Instructions. First Steps Childcare state staff can be reached by calling: 1-888-889-7514.

MAA expects all MCM and MSS team members who authorize childcare to read and be familiar with the First Steps Childcare Billing Instructions. Go to: http://maa.dshs.wa.gov (Provider Publications/Fee Schedules) to view MAA's First Steps Childcare Billing Instructions.

Before MAA will make payment for childcare, a background check is required for all unlicensed childcare providers. It is the intent of this policy that background checks be completed prior to the provision of childcare.

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Billing/Fee Schedule

Billing Information Specific to MSS

MAA will reimburse the MSS provider for services rendered on a fee-for-service basis according to standard MAA policies and procedures.

The MSS provider determines whether the services are to be delivered in the home or in the agency. A home visit may be billed for services provided at the client's place of residence, or in the hospital if the MSS agency is not hospital-based. If a home visit is not possible, such as in the case of an unsafe place of residence or a potential problem with client information, an alternate, off-agency site may be used and billed as a home visit. The reason for using an alternate site of visitation must be documented in the client's record.

You must have an individual, face-to-face contact with the pregnant/postpregnancy client before billing any of MSS listed in the fee schedule, **except** the Family Planning Performance Measure (state-unique procedure code 0423M). Only services provided to the pregnant/postpregnancy client may be billed.

Do not bill for group visits except for childbirth education.

The postpregnancy period applies to the two months following live birth, miscarriage, fetal death, or termination of pregnancy.

You must include the pregnant/postpregnancy client's patient identification code (PIC) on all claims for MSS. The PIC can be found on the client's Medical ID card. **Do not use the infant's PIC to bill MAA for MSS services.**

MSS Visits

(State-unique procedure codes 0400M - 0405M, 0420M, and 0421M)

- The following are included in the MSS fees:

  - ✓ Assessment;
  - ✓ Provision and development of plan(s) of care;
  - ✓ Intervention services and counseling; and
  - ✓ Coordination with the maternity case manager, the MSS interdisciplinary team, and the prenatal care provider.

- Do not bill the **same procedure code** with the same PIC number more than once per day.

  Example: Client is seen in a clinic setting twice in one day by the community health nurse. Only one billing is allowed under procedure code 0400M, even if the client was seen twice.

- Agencies may bill **different procedure codes** under one PIC number on the same day.

  Example: Client is seen for a home visit by the community health nurse and nutritionist on the same day. Agency may bill under the same PIC number for procedure code 0401M and 0402M for services provided on the same day.

- Community health worker (CHW) visits include basic health education and intervention for clients receiving Maternity Support Services. All CHW activities are carried out under the direct supervision of one of the following members of the MSS team:

  - ✓ Community health nurse;
  - ✓ Psychosocial worker; or
  - ✓ Nutritionist.

- MAA covers up to ten MSS visits per pregnancy/postpregnancy period per client. If a client is at high-risk* for a poor birth outcome, MAA covers up to 20 MSS visits per pregnancy/postpregnancy period. Maternity case management (MCM) visits do not count towards the maximum of 20 MSS visits.

  High-risk clients are those meeting the eligibility criteria for maternity case management (see page E.2). Document of client's MCM eligibility criteria in the client's chart that allowed for the 10 additional visits.

- MSS providers must not bill for WIC services provided under a WIC certification, nor for the WIC Second Nutrition Education Contact. Additional nutrition visits provided by the MSS nutritionist during WIC appointments are billable when they are an integral part of the interdisciplinary MSS plan of care.

First Steps Childcare Authorization

(State-unique procedure code 0406M)

An MSS provider can receive reimbursement for authorizing childcare for clients not receiving MCM services. Authorization can be billed only **once per client**, per pregnancy/postpregnancy period. **Reimbursement is not allowed for screening only**. See MAA's First Steps Childcare Billing Instructions for further details about authorizing childcare.

Childbirth Education

(State-unique procedure code 0410M)

This is a series of sessions totaling at least 8 to 16 hours that can be provided either in group or individual classes, according to the needs of the client. This service can be billed only **once per client**, per pregnancy. The client must attend at least one class in order for an approved provider to bill for this service.

Family Planning Performance Measure

(State-unique procedure code 0423M)

An MSS provider may bill the family performance measure procedure code if the six-week postpregnancy family planning information has been collected and documented as described in Section E under Current Performance Measure. This procedure code may be billed **only once per client**, per pregnancy.

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

Note:	If MAA has recouped a plan's premium, causing the provider to bill MAA, the time limit is 365 days from the date of recoupment by the plan.

1 **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

2 **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

What if a client becomes pregnant again before MSS is terminated?

When billing for MSS, enter the new "Due Date" in field 19 on the HCFA-1500 claim form. This "resets" the clock for the new pregnancy. All future MSS visits/billing will be for the new pregnancy.

Fee Schedule

Refer to page A.2 for information on MSS visits.

	State-Unique Procedure Code	Description	Maximum Allowable Effective 7/1/02
	0400M	MSS Community Health Nursing Visit	$58.00
*	0401M	MSS Community Health Nursing Home Visit	$91.15
	0402M	MSS Nutrition Visit	$58.00
*	0403M	MSS Nutrition Home Visit	$91.15
	0404M	MSS Psychosocial Visit	$58.00
*	0405M	MSS Psychosocial Home Visit	$91.15
	0420M	MSS Community Health Worker Visit	$30.40
*	0421M	MSS Community Health Worker Home Visit	$45.70
	0406M	First Steps Childcare Authorization	$26.00
	0410M	Childbirth Education	$60.00
	0423M	Family Planning Performance Measure	$10.00
		The First Steps team must decide which MSS discipline should bill. Teams that have members from more than one agency should decide which agency would bill. Bill during the post-pregnancy MSS eligibility period when the performance measure documentation is completed. MSS Unintended Pregnancy Performance Measure - Question 4a and b on the Family Planning Interview Guide must be documented in the client's chart.	

* Home Visit Codes

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, faxed, or laser printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process or will actually **black out** information. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light or faded.**

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description

1a. **Insured's ID No.**: Required. Enter the Patient Identification Code (PIC) - an alphanumeric code assigned to each MAA client - exactly as shown on the client's DSHS Medical ID card that consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

19. **Reserved for Local Use** – Enter the estimated due date for newly pregnant MSS clients.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) **Print in field 19 "SEE BOX 22."**

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., March 4, 2002 = 030402).

Do not use slashes, dashes or hyphens to separate month, day year.

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code Number	To Be Used For
3	Office or ambulatory surgery center
4	Client's residence
9	Other (specify where the visit occurred in field 32.)

24C. **Type of Service**: Required. Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate procedure code from these billing instructions.

24E. **Diagnosis Code**: Required. Enter V99.1.

24F. **$Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. One per each procedure billed.

25. **Federal Tax ID Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: If you receive an insurance payment or client paid amount, show the amount here, and attach a copy of the insurance EOB. Enter the name of private insurance company in 9D. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use a dollar sign or decimal point or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

Group: This is the seven-digit number assigned by MAA to a provider group that identifies the entity (e.g., clinic, lab, hospital emergency room, MSS provider, etc.). When a valid group number is entered in this field, payment will be made under this number.

Enter the MSS provider number assigned to you by the Medical Assistance Administration when you signed your Core Provider Agreement. This is a seven-digit provider number that appears on the Remittance and Status report received with reimbursement for services. Please use this number in field 33.

SAMPLE CLAIM FORM

(See separate Adobe file.)